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ABSTRACT

In January 1995, the nursing program at St. Petersburg Junior College (SPJC), in Florida, undertook a project to enable nursing students to move from hospital- to community-based practice. Specifically, the project sought to establish partnerships with the health care agencies and facilities in the community, develop a community-based health care curriculum, develop a replicable model for community out placements, identify qualified area nurses to supervise and evaluate students in their out placement experiences, and provide inservice training to SPJC faulty. An Advisory Committee was formed and 33 SPJC nursing faculty were consulted throughout the project regarding curriculum development and out placement site assessments. As a result of the project, 11 new contracts were completed for out placement learning sites. In addition, the nursing curriculum was updated through the development of modules focusing on unique settings, such as home health and hospice care, and including theory and objectives of clinical learning and worksheets and evaluation forms for students' clinical experiences. The bulk of this report provides the updated curriculum for the hospice, home health care, and middle aged & older adults modules, including course outlines and materials used in instruction. The evaluation forms for student out placement are included. (TGI)

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ED 398 949

St. Petersburg Junior College Nursing Program

FINAL REPORT: AACC/MET LIFE FOUNDATION GRANT

Project Title: *Partnerships Of Nursing Education In Community Settings*

Project Director: Dr. Mary Jean Etten

PARTNERSHIPS

S.P.J.C. Nursing Faculty

The Hospice Of The Florida Suncoast

Morton Plant Health Ventures

Bayfront Health Services

JANUARY 1995-JANUARY 1996

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PURPOSE

Changes in the health care delivery system necessitate that nursing graduates be able to move from hospital-based practice to community-based practice. St. Petersburg Junior College Nursing Program proposed to expand a pilot project that allows students to accomplish this. In partnership with multiple community agencies the Nursing Program will identify sites, develop curriculum, supervise and evaluate students, and provide inservice.

OUTCOMES OR OBJECTIVES

1. Establish partnerships/contracts with at least ten new home health agencies, community programs, clinics, long term facilities, or rehabilitation units.

2. Identify 70 qualified registered nurses in home health and other settings to supervise students.

3. Offer inservice education to faculty to increase their knowledge of national health care reform and the need for teaching in alternative settings.

4. Agency representatives will present guest lectures in theory classes.

5. Develop objectives, and guidelines for student out placement experiences.

6. Evaluate students' clinical experience, agencies used and clinical associates functioning.

7. Explore a variety of alternative educational programs, and staffing models such as post-graduate, home health courses, certification programs, and joint faculty appointments.

8. Develop a model of community out placements that can be replicated by other nursing programs.

LONG RANGE GOALS (OUTCOMES)

1. Incorporate out placements/home health experience from two to four nursing courses as permanent part of the curriculum.

2. Improve faculty skill level in facilitating education of students in out placement settings.

3. Sustain contractual relationships and form new ones. Maintain working relationships established during project period and establish similar relationships with additional agencies.

4. Identify and support new clinical associate relationships with registered nurses who will supervise students in alternative clinical settings.

5. Sustain joint venture Continuing Education programs: develop new educational ventures.

6. Submit an abstract for presentation at the Council of Associate Degree Programs, National League of Nursing Convention.

PARTNERS ROLE IN THE GRANT

Collaborative development of:

1. Agency assessment as a placement site.

2. Methods to identify qualified nursing staff to serve as clinical associate.

3. Policies and procedures to guide the student placement experience.

4. Evaluate criteria for the clinical experiences.

5. Roster of qualified personnel from community partner agencies to serve as educators for students in the class setting and for faculty.

6. Proposed modifications in the nursing curriculum to better prepare graduates to function in the world of health care reform.

7. Post graduate-level course/programs to prepare nurses to function in non-hospital settings.

8. Strategies to evaluate the entire project.

PROGRESS AND ACCOMPLISHMENTS OF THE GRANT

A. An Advisory Committee was formed consisting of twenty-four members. The committee met six times.

B. The purpose and objectives of the grant was presented to 33 SPJC nursing faculty members. They were regularly consulted and actively involved in the following aspects of the grant:

1. Developing of the student learning modules and evaluations for the out placements.

2. Ninety-five percent of the faculty attended several workshops related to health care reform, and nursing care in alternative settings. The nursing department sponsored a day long workshop for faculty on health care reform and its implications for nursing education. Open campus offered free tuition to faculty who wished to attend workshops.

3. Supervising students in out placement settings.

4. Visiting and assessing potential clinical sites.

5. Evaluating the out placement clinical experience from the Instructor perspective.

6. Continual input into developing grant materials as well as procedural aspects of carrying it out.

C. A bulletin board in the faculty lounge posted upcoming workshops related to health care reform and alternative clinical learning sites.

D. An information notebook was initiated in the faculty lounge, in it were placed journal articles and conference handouts on health care reform and teaching in alternative learning sites.

E. Twelve clinical agencies were visited by administration and faculty to evaluate them as potential learning sites.

F. Eleven new contracts were completed for new out placement learning sites. Ongoing positive relationships were maintained with these agencies and others that were visited during the granting period.

G. The Advisory Committee and The Parnership Agencies participated in:

1. Assisting in the development of criteria for selection of new clinical teaching sites.

2. Identifing qualified nurses to function as Clinical Associates.

3. Assisting in the development of the student learning modules for outplacements, the evaluation tools, and policies and procedures. They also make suggestions for curriculum changes.

4. Assisting in the development of the Clinical Associate packet.

5. Identifing nurses in the agency who could teach classes on home health care and hospice. Six agency nurses and staff taught classes to 415 nursing students.

6. Participating in the development of post graduate courses or programs on nursing in out placement settings.

7. Assisting in completing the evaluation of the project.

H. Developed modules including objectives, course outline, focus sheets and evaluation instruments for theory and clinical learning for hospice and home health, surgical centers, long term care, and other out placement settings.

I. Developed a clinical associate packet and evaluation instruments.

J. Presented orientation classes to 125 nurses and administrators at Bayfront Home Health Services, Morton Plant Health Ventures, Hospice of the Florida Suncoast, And St. Anthony's/St. Joseph Home Health Care.

K. Produced a video presentation of the orientation for Clinical Associates. Video and audio tape copies of the presentation were made then given to out placement agencies for initial or continued Clinical Associate orientation.

L. Utilized a video tape of nursing students discussing their experience with Hospice of the Florida Suncoast as a clinical out placement in Clinical Associate training classes.

M. Produced a video tape, of Dr. Kelly from Hospice of the Florida Suncoast, teaching nursing students hospice concepts of care.

N. Open Campus of the college in cooperation with the Nursing Department initiated several new courses for registered nurses and new graduates. They include: Introduction to Home Health Care, Introduction to Ambulatory Care, Introduction to Hospice Care, I.V. Therapy, and others.

O. Evaluations were completed by: a) the Clinical Associate on the Student, b) the Student regarding the out placement experience, c) the Clinical Associate regarding their role as Clinical Associate, d) Faculty regarding their responses to students learning in out placement settings.

P. Dissemination of the grant:

1. Poster session on the project presented at Career Forum in Tampa Florida. (October, 1995) It was awarded third prize.

2. Presentation on the project made by Dr. Parks at the National Organization For Associate Degree Nursing Conference in Los Angeles,California. (October, 1995).

3. Poster session to be presented at the National League For Nursing, Council Of Associate Degree Programs in Atlanta, Georgia. (April, 1996)

4. Abstract written and submitted for the Florida State Hospice conference. Orlando, Florida. (September, 1996)

5. Abstract being written for submission to the National Hospice Organization Conference in Chicago, Illinois. (November, 1996)

6. Abstract being written for submission (poster session) at the National American Journal Of Nursing Conference in Orlando, Florida. (October, 1996)

7. Press releases sent to periodicals: Nursing Spectrum and Vital Signs.

8. A fact sheet was developed to inform professionals of the grant, its focus and goals.

Q The model developed for the project can be replicated by other Associate Degree Nursing Programs throughout the United States.

FINAL REPORT: AACC/MET LIFE FOUNDATION GRANT

Challenges - Successes

CHALLENGES

1. To accomplish all the objectives and goals outlined in the grant in the small amount of time designated. The project director, Dr. Wittman, and Dr. Parks spent many hours beyond the time allotted by the grant.

2. How to continue the goals of the grant and keep abreast of the ever changing health care system without additional financial support from the grant.

3. Engaging faculty in learning about health care reform and responding to changes through the use of more out placement experiences for students.

4. Investigating possible options to use for student out placement learning.

5. Setting up criteria that defines quality learning experiences in out placement settings.

6. Inviting a professional from the Agency for Health Care Administration to sit on the Advisory Committee.

7 To continue the Advisory Comittee beyond the granting period.

SPECIAL SUCCESSES

1. Heightening awarenesses of the faculty regarding the rapidly changing aspects of health care reform and its influence on nursing education.

2. Building partnerships and ongoing relationships not only with the Advisory Committee and Partnership Agencies but also with many other community health care professionals and settings.

3. Developing an innovative replicable model for educating A.D. Nursing students that better prepares them for nursing in the era of health care reform.

4. Presenting the project at several professional meetings.

5. The majority of student responses were positive regarding their learning experiences in out placement settings.

6. The nurses' positive evaluations of their role as Clinical Associate.

7. Initiating a collaborative experience among community agencies and the nursing program by examining the impact of health care reform on education and designing a model for teaching in this new environment.

8. The development of post-graduate courses addressing nursing practice in alternative health care settings.

9. Other Community College Nursing Programs are seeking our assistance in developing out placement experiences for their nursing students.

CONCLUSIONS

The grant has given us the opportunity to address the implications of health care reform for nursing education. Our goal in the St. Petersburg Junior College nursing program is to prepare nursing graduates to the best of our ability to function in the current health care arena. Faculty were updated on health care changes and their implications for nursing education. Furthermore we were able to gain a greater understanding of changing health care practice settings nationally, and in this geographic area by assessing various agencies and developing new contracts and relationships with them.

The nursing curriculum was updated through the development of modules describing; the objectives for theory and clinical learning, the course outline, the clinical focus sheets and an evaluation tool for the student to evaluate the experience and the Clinical associate (RN).

A special module was written for registered nurses who functioned as Clinical Associates for the students in out placement settings. This includes guidelines and objectives of their role, theoretical content on teaching in a clinical setting, and a form to evaluate student performance.

Nursing faculty, the partnering agencies, and the grant advisory committee played important roles by offering continued input and advice, through developing of learning materials, and by evaluating of the project.

Evaluation data by students support the excellence of these learning experiences in out placement settings. Nurses expressed a willingness to continue to function as a Clinical Associate. The majority of the Clinical Associates rated students as above average or excellent for most of the items on the evaluation. Faculty evaluations of the out placement experience for student learning identified positive and negative aspects of the experience as well as suggestions for change.

We believe we have been able to develop a unique, innovative model for teaching nursing in Associate Degree Nursing education that is responsive to the changing health care arena. Furthermore, we believe this model is replicable in other nursing programs across the United States.

UNANTICIPATED SPINOFFS

The project has raised the consciousness of other nursing educators who are now interested in knowing more about the project and are asking for some of the modules etc.

We have begun to develop a new model for the cooperation of nursing service from many outplacement settings to partner with nursing education. This model warrents further development as a cutting edge approach to the many and continued changes in the health care delivery system.

The positive responses of the nursing students experiencing out placement learning.

The positive responses from the out placement agencies and from the Clinical Associates.

The willingness for the nursing faculty to learn about health care reform, to develop appropriate learning tools and to participate in the guidance of students and evaluation of the project.

NEW CONTRACT AGENCIES

ARBORS OF SAFETY HARBOR

BOLEY INC.

COMMUNITY DIALYSIS CENTERS OF FLORIDA

INTEGRATED HEALTH SERVICES OF FLORIDA AT TARPON SPRINGS

INTEGRATED HEALTH SERVICES OF FLORIDA OF PINELLAS PARK

DR. BOYD MULLHOLAND

PINELLAS EMERGENCY MENTAL HEALTH SERVICES

ST. PETERSBURG FREE CLINIC

ST. PETERSBURG MULTISERVICE SENIOR CENTER

TOTAL PROFESSIONAL HEALTH CARE

WOMEN'S AND CHILDREN'S HEALTH CENTER

FACT SHEET

ST. PETERSBURG JUNIOR COLLEGE NURSING PROGRAM, AACC/METLIFE GRANT

In response to the changing health care delivery system and the need to prepare nursing students to function in alternative health care settings, St. Petersburg Junior College Nursing Program has received a grant from AACC/Metlife to partner with the health care community to develop a model of collaborative outplacements for nursing students in a variety of community health settings.

The nursing program faculty along with a community advisory committee are identifying settings for student learning such as long term care, clinic, senior center, birthing center, hospice, and home health care. Together they are developing the protocol for learning. Following an orientation, registered nurses will be clinical associates and function as role models and teachers for assigned nursing students. Specific learning packets designed to optimize the learning experience are being designed along with evaluation instruments.

Faculty are attending workshops on health care reform and community agency professionals are presenting classes and workshops for both faculty and students describing various approaches to health care.

Dr. Mary Jean Etten is the Project Director. Any questions regarding grant may be directed to her at 341-3618.

Article submitted for publication of the grant

A Model for Teaching Nursing in the 21st Century

Health care reform is resulting in a myriad of changes in the health care delivery system such as mergers, managed care, and hospital closings. Hospital stays are shorter, and more patient care is given in alternative care settings, especially the home.

In response to these (current and predicted changes) and to better prepare nursing students for these alternative practice settings St. Petersburg Junior College Nursing Program, under the leadership of Dr. Jodi Parks wrote and received a grant from AACC/Metlife to develop a model for teaching nursing students to better function in these settings. In partnership with the Hospice of the Florida Suncoast, Morton Plant Mease Home Health and Bayfront Home Health, the community advisory committee and nursing faculty, the model was developed and implemented in a variety of health care settings. The grant is under the direction of Dr. Mary Jean Etten Project Director and Dr. Janice Wittman Administrator.

Workshops to update faculty regarding health care reform issues, and teaching in alternative care settings were offered for faculty as well as the opportunity for them to observe nursing care in a variety of agencies. A panel of home health care and nursing home nurses presented a workshop for the nursing faculty describing the nurse's role in these settings.

Potential community health care settings were initially evaluated and a variety of clinical teaching sites identified. Among these are hospice, home health, long term and subacute care, rehabilitation centers, surgical centers, birthing center, mental health centers, and others. Specific curriculum modules were then developed focusing on the unique setting such as home health and hospice care. The modules include theory and clinical objectives, specific clinical worksheets and an evaluation form for students to evaluate the experience. Agency nurses presented classes to students describing their unique type of nursing care. A variety of health care settings serve as clinical learning sites.

Clinical associates (RN's) supervise students' practice in these various settings. A clinical associate orientation module was written which describes their role and clinical teaching approaches. An orientation presentation by nursing faculty and administration further prepared the clinical associates for the role. A video and audio tape was available for additional instruction. Following the teaching experience with a student the nurse completes an evaluation of the student's performance which is factored into the student's final clinical grade for the course. At the end of the semester, clinical associates evaluate their role of clinical associate.

Evaluative data indicate the model is a very valuable learning experience for nursing students. The majority of their responses to the questionnaire were excellent or very good. Written reactions further

support these findings. Student's comments included; "The nurses are wonderful and I could see how hospice provides holistic care", "I saw the interdisciplinary team working together to give the best possible care", "The information I received about care plans and pain medications was so valuable", 'This clinical experience played a vital role in my nursing education"., "It helped me examine my own feelings of death and see another side of nursing". A video tape made by students acclaim the benefits of the hospice experience and is used in orienting hospice clinical associates. Clinical associate's evaluation of the students and their role as clinical associate showed positive outcomes. Their comments of students included; "Student was sensitive to the patient's psychosocial as well as the physical needs", "Student was compassionate, caring, knowledgeable, and interested in learning", "Student was considerate, professional, confident, friendly, and concerned for the patient's comfort and dignity". The grant has allowed St. Petersburg Junior College Nursing Program to expose students to a variety of nursing settings and opened the door to new employment opportunities.

NUR 2732 - 2732L

NUR IV

Hospice
Home Health Care
Middle Aged & Older Adults

1995-96

Printed on 50% Recycled Paper

St. Petersburg Junior College

NUR IV

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HOSPICE

NURSING THEORY AND CLINICAL

SCHOOL YEAR 1995-96

ST. PETERSBURG JUNIOR COLLEGE NURSING PROGRAM
NUR 2732-2732L - NURSING IV

HOSPICE NURSING CARE THEORY

UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
1. Define the meaning of the Hospice philosophy of care for the dying.	I. The Meaning of the Hospice Model of Care	1. Read brochures.
2. Discuss the history of the Hospice movement and that of the Hospice of the Florida Suncoast.	2. History of Hospice a. Internationally b. Hospice of the Florida Suncoast	2. Appendices #5.
3. Discuss the basic characteristics of Hospice care for the dying and their significant others.	3. Basic Characteristics of Hospice Care a. Patient and family are unit of care b. Pain and symptom control c. Care provided by a multidisciplinary team d. Care provided 24 hours a day 7 days/ week e. Bereavement follow-up f. Home care and inpatient care g. Volunteers support	3. Read brochures.

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UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
4. Identify the sources of financial support for Hospice care.	4. Sources of Financial Support a. Medicare b. Medicaid c. HMO, PPO d. Private insurances	4. Read "Facts About Hospice."
5. Compare and contrast Hospice Care vs. Home Health care.	5. Types of Care a. Hospice care b. Home health care	5. Appendix #2.
6. Identify criteria for admission to Hospice care.	6. Hospice Admission Criteria a. Referral from physician b. Resident of Pinellas County c. Patient has a primary care giver d. Patient's life expectancy less than 6 months (These vary, Hospice inpatient facility is available now)	6. Listen to lecture.
7. Discuss assumptions regarding Hospice care.	7. Assumptions Regarding Hospice Care a. General assumptions	7. Appendix #8.

UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
	b. Patient oriented assumptions c. Family oriented assumptions d. Staff oriented assumptions	
8. Describe the scope of services available to patients at the Hospice of the Florida Suncoast.	8. Services Available a. Multidisciplinary team 24 hours a day, 7 days per week b. Social services c. Home care d. Continuous home care e. Inpatient respite care d. Inpatient care general care	8. Read sheet "Facts About Hospice," Appendix #1. View video Hospice Caring for the Community.
9. Compare and contrast the phases of terminal care of the dying.	9. Phases of Terminal Care a. 6 months b. 5 months c. 4 months d. 3 months e. 2 months	9. Read brochure on "Phases of Terminal Care."

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UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
	f. 1 month g. After death	
10. Describe unique approaches to pain control.	10. Approaches to Pain Control a. Pain assessment and monitoring b. Pharmacological approaches c. Physical d. Psychosocial e. Invasive interventions	10. Read brochure "Management of Cancer Pain: Adults."
11. Discuss approaches to symptom control.	11. Symptom Control a. Respiratory and Cardiovascular b. Skin and mouth c. Gastrointestinal d. Genitourinary e. Dehydration and fatigue	11. Appendix #6. View video, Walk Me to the Waters.

UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
12. Identify psychosocial need of the dying and significant others.	12. Psychosocial Need of Patient and Family a. Loss and grief b. Loneliness and isolation c. Fear and Anxiety d. Helplessness of patient and family e. Uselessness f. Anger and conflict g. Depression h. Loss of sexual intimacy i. Caregiver fatigue j. Spiritual k. Sociocultural	12. Appendix #7. Read "Death and Grief in the Latter Years" in book, Physical Change and Aging: A Guide for the Helping Professions by Saxon, S.V. and Etten, M.J. On reserve and in stacks in the library.
13. Discuss therapeutic approaches with the dying and their significant others.	13. Therapeutic Approaches a. Teaching b. Communication C. Community resources	13. Appendix #8.

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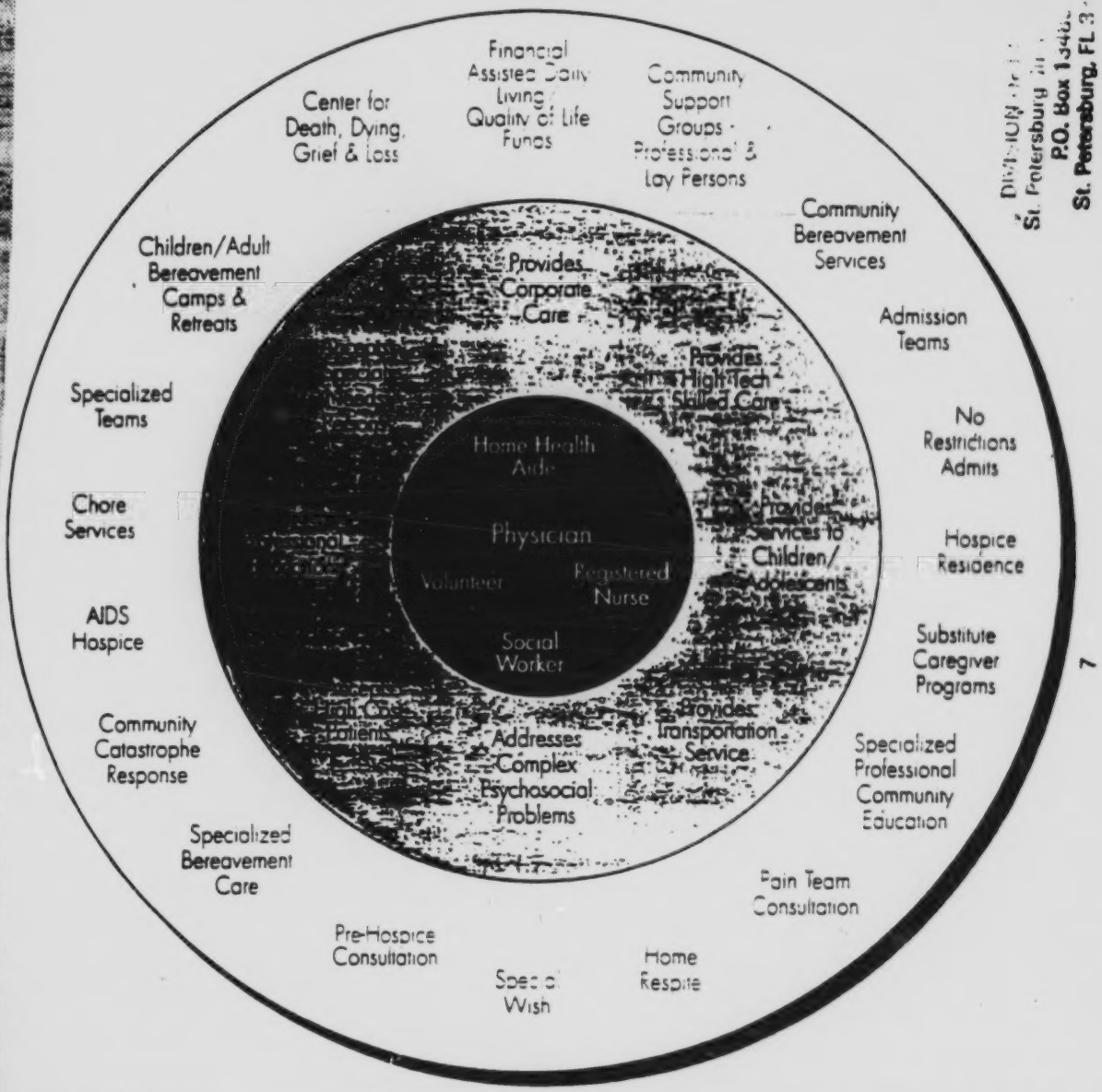
P.O. Box 13489
St Petersburg, [illegible]

APPENDIX 1

THE HOSPICE CENTER OF EXCELLENCE:



The Hospice of the Florida Suncoast is a comprehensive, community-based non-profit agency providing Pinellas County citizens with palliative technologies, medical care, and emotional/spiritual support services for anyone with a terminal illness. Hospice also serves survivors and patients' families by providing community responsive emotional support and grief counseling services. Care is delivered without regard to age, race, faith, diagnosis or ability to pay. Founded in 1977 by volunteers, Hospice will serve more than 5,000 terminally ill people, their families and survivors this year. Hospice responds to its community's needs.

THE HOSPICE OF THE FLORIDA SUNCOAST
Caring for Pinellas County, Florida, since 1977

300 East Bay Drive • Largo, Florida 34640
(813) 586-4432

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SPJC

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NUH/NUR2732/HOSPICE.NUH
July 13, 1995

APPENDIX 2

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Comparing Hospice Care and Home Health Agencies

Hospice's interdisciplinary care team meets the complex needs of patients who have a life-limiting or terminal illness. Hospice also provides services for families, loved ones and survivors.

Services:	The Hospice of the Florida Suncoast	home health agencies
Nursing, psychosocial, spiritual care and volunteer assistance available 24 hours	•	nursing on-call only
Admissions completed within 2 hours of referral - 24 hours a day, 7 days a week.	•	day after facility charge
Case management programs in hospitals, nursing homes, ACLFs and residences	•	no
High-tech nursing	•	•
Home health aides	•	•
Social service and counseling programs for families and individuals	•	social services only
Physician medical director is a consultant to care team	•	no
Spiritual care counseling	•	no
Volunteer support services	•	no
Specialized pediatric/adolescent program	•	no
Infusion services (in-house)	•	some
Pharmacy services (in-house)	•	some
Respiratory services (in-house)	•	some
Physical therapy/Occupational therapy/Speech therapy	•	•
Short term continuous care for skilled needs	•	no
Durable medical equipment (in-house)	•	some
Caregiver respite program	•	no
Support and bereavement counseling programs for families	•	no
Residential program (Hospice House)	•	no
Bereavement group for children and adolescents	•	no
Home visits at time of death	•	no
Financial Issues:		
Medicare/Medicaid certified	•	Medicare only
No deductibles (Insurance, Medicare)	•	no
Care continued after benefits depleted	•	no
Provides disease-related medications	•	no
Provides services regardless of ability to pay	•	no

The essential difference between Hospice and home health care is that "hospice" is a philosophy of care, whereas traditional home health" is a method of delivering care.

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HOSPICE

"My strongest objection to the vision for the dying that Jack Kevorkian has given to America concerns not suffering but missed opportunity."

"The transition from life can be every bit as profound, intimate, and precious as the miracle of birth."

"The surprising fact is that in the midst of their dying, many people are able to experience not merely comfort but an increased sense of well-being, which often includes a deep sense of connectedness to others and the world."

"This is not some religious tract or wistful, new-age thinking. It is the direct experience of clinicians who are privileged to care for the dying in modern hospice-like settings."

Ira Byock, M.D. Hospice Physician

HOSPICE PHILOSOPHY AND PRINCIPLES

Hospice is a "concept of care, the goal of which is to help a person be fully alive until he or she dies"

Hospice affirms life.

Hospice exists to provide support and care for persons in the last phases of incurable disease so they might live as fully as comfortable as possible.

Hospice recognizes dying as a normal process.

Hospice neither hastens nor postpones death.

Hospice exists in the hope and belief that with appropriate care by a community sensitive to their needs, patients and families may be free to attain a degree of mental and spiritual preparation for death.

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HISTORY OF THE HOSPICE MOVEMENT

The history of hospice goes back many years.

Hospice goes back to the beginnings of Christianity where there were "Hospital" run by religious orders which emphasized hospitality for the sick, the poor, and the dying. During the Crusades, the universal idea that the person who is dying is a metaphorical traveler at a stopping place on a long journey that will be continued after death was the current thinking. Whether the travelers to the Holy Land succumbing to fatigue, disease, and wounds or symbolic journeyers on a way station in life, the dying received particular attention. They were honored and treated with great care, and were valued as persons "moving more rapidly than others on a metaphysical plane.

In the 1600's St. Vincent de Paul founded the Sisters of Charity in Paris. They opened hospitals to care for the sick and the dying. Over 100 years later the first Protestant hospice, Kaiserwerth, was opened in Prussia.

The first institution to serve as the basis for the modern day hospice was Our Lady's Hospice founded in Dublin by the Irish Sisters of Charity in the late 1800's. It was dedicated to the care of the dying. In 1902, five of these Sisters opened St. Joseph's Hospice for the dying poor in England.

Sixty-five years later in 1967, Dr. Cicely Saunders opened St. Christopher's Hospice in London, which became the model for today's hospice care. St. Christopher's is an ecumenical religious and medical foundation combining the best care for the dying and with opportunities for teaching and research in the fields of medicine, nursing, and allied health.

In 1974, the first hospice, called Hospice Inc., began as a demonstration project funded by the National Cancer Institute. Since then about 2,500 Hospices have opened in the United States.

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APPENDIX 5

The Hospice of the Florida Suncoast

Program Summary

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The Hospice of the Florida Suncoast is a community-based non-profit agency serving Pinellas County, Florida with a comprehensive program of medical care and emotional and spiritual support services for anyone with a terminal illness. Currently caring for more than 1,100 patients each day, Hospice is presently the only health care system in Pinellas County that provides a holistic approach to caring for dying patients and their families.

Hospice care is available 24 hours a day, seven days a week and is delivered without regard to age, race, faith, diagnosis or ability to pay. Founded in 1977 by volunteers, The Hospice of the Florida Suncoast now serves more than 3,500 terminally ill people and their 12,500 family members each year. Care is delivered by 600 fulltime health care professionals and more than 1,300 volunteers who provide approximately 70,000 volunteer hours each year.

The focus is on keeping patients in their own home for as long as possible. However, hospice care is also offered in a variety of other settings, appropriate to an individual's need, when staying home is no longer possible. In addition to their own homes, patients are also cared for in more than 100 area nursing homes and at two Hospice Houses. Hospice House Viewtop is a 6-bed residential facility and Hospice House Woodside is a larger residential inpatient facility with 75 patient care rooms, congregate family and dining rooms and three screened gazebo areas in a park-like setting. Woodside also has 20 one-bedroom apartments. This eliminates the need for visitors to sleep on couches and chairs in patient's rooms, or in nearby hotel rooms, and allows families to spend their final days together.

Other programs offered by The Hospice of the Florida Suncoast include the Hospice Caregiver & Community Resource Program which provides caregivers for patients wanting to remain in their own homes; The Hospice Bridges Program which offers bereavement counseling and support to individuals and families through the Hospice program, as well as in the community and the workplace. The Hospice Child & Family Support Program which provides a variety of support services to children and their families both through the Hospice program and the Pinellas County School system. This program also hosts Camp LLL, an annual weekend bereavement camp for children; Joining Generations Intergenerational Volunteer Program which pairs senior Hospice volunteers with local high school students who work at Hospice House Woodside.

In 1994, The Hospice Institute of the Florida Suncoast was operationalized to serve as the agency's research and education component. The Hospice Institute has been funded by the National Cancer Institute of the National Institutes of Health to develop the Hospice Certification Program which will provide training in hospice and palliative care to hospice professionals throughout the country. The Certification Program provides health care professionals - specifically nurses, psychosocial counselors and chaplains - with knowledge and clinical skills they need to then implement this training program in their own hospice facilities.

The Hospice of the Florida Suncoast serves as a volunteer consultant to hospices throughout the state of Florida, and the United States, and has been called on by many national groups to speak to issues related to care for dying people.

SYMPTOM CONTROL FOR THE DYING

RESPIRATORY PROBLEMS

Dyspnea

1. Reduce anxiety
2. Diet and fluid restrictions
3. Monitor oral hygiene
4. Change patient's position
5. Modify the environment

Cough

1. Change positions
2. Warm and humidify the air
3. Teach cough and deep breathing
4. Expectorants
5. Antihistamines
6. Narcotics
7. Bronchodilators

CARDIOVASCULAR PROBLEMS

Edema

1. Changing medication
2. Compression hose
3. Diuretics
4. Elevation of the legs
5. Exercise

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SKIN AND MOUTH

Pruritus

1. Cooling bath with soda bicarbonate
2. Cooling lotions, calamine
3. Corticosteroids
4. Antihistamines
5. Avoiding coffee and alcohol

Dry Mouth

1. Glycerin, normal saline
2. Hydrophilic chewing gum
3. Hard candy
4. Methylcellulose

Taste Changes

1. Assess tastes person has aversions to
2. Offer only foods person finds pleasant

GASTROINTESTINAL

Dysphagia

1. Keep head elevated 30 minutes post meals
2. Deal with the causes of dysphasia
3. Excellent mouth care
4. Soft foods or blenderized foods
5. Liquid drugs or suppositories
6. Evaluate use of gastrostomy or nasogastric tube
7. Take small swallows

Nausea and Vomiting

1. Assess for the cause
2. Modify the diet
3. Offer small frequent meals
4. Increase use of broths, jello, soft bland food, soft drinks, soda crackers, soups,
5. Decrease fatty foods and those that smell strongly
6. Antiemetic prior to meals
7. Frequent oral hygiene
8. Use alternative therapies; relaxation, guided imagery, muscle relaxation
9. Insure adequate nutrition

Constipation

1. Maintain adequate hydration
2. Administer stool softeners and other cathartics
3. Check for an impaction
4. Assess medication taken

Diarrhea and Dehydration

1. Assess for causes
2. Check for an impaction
3. Maintain hydration
4. Protect the skin and keep skin clean
5. Modify the diet
6. If caused by stress use relaxation techniques
7. Avoid extremely hot or cold food or irritating foods
8. Offer ice chips, popsicle
9. Swab the mouth with normal saline or lemon essence
10. Maintain excellent mouth care

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GENITOURINARY

Urinary Incontinence

1. Identify the cause
2. Limit fluids especially at night
3. Use Attends, urinals, other products to catch the urine
4. Use excellent skin care
5. Modify clothing to ease voiding
6. Rearrange the environment such as furniture, nearness to the commode or bathroom

Weakness and Fatigue

1. Us assistive devices
2. Use range of motion if possible
3. Gradually increase activities when possible
4. Use warm not hot water for baths
5. Assess for depression
6. Plan rest periods
7. Modify the environment for ease of use
8. Steroids

NEUROLOGICAL

Confusion, Dementia, and Delirium

1. Identify the cause
2. Avoid sensory overload, maintain a quiet environment
3. Use reality orientation or validation therapy as appropriate
4. Support the family
5. Administer antipsychotic medications
6. Evaluate the drug regimen
7. Evaluate the presence of pain

Depression

1. Assess causes
2. Administer antidepressants
3. Psychosocial support
4. Encourage individual to talk
5. Enhance sense of self
6. Spiritual support

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PSYCHOSOCIAL NEEDS AND INTERVENTIONS OF THE DYING AND THEIR SIGNIFICANT OTHERS

LOSS AND GRIEF

1. Encourage them to share their feelings of loss and their meaning
2. Validate the losses they experience
3. Encourage support from family and friends
4. Offer spiritual support
5. Help person to think about that which is still there for them such as people, and relationships
6. Help them to celebrate each moment of each day

ISOLATION AND LONELINESS

1. Be present to the individual in a meaningful way
2. Offer spiritual support
3. Encourage support by the family and friends
4. Refrain from generalizations minimizing their feelings of loneliness
5. Pray with the person, if acceptable with them

ANXIETY AND FEAR

1. Identify the specific sources of anxiety and fear
2. Be open with the individual and answer questions truthfully and sensitively
3. Explain procedures, meaning of symptoms, and progress of the disease
4. Realistic reassurance on a regular basis
5. Assure them they will not be abandoned, follow words with actions
6. Encourage the person to communicate freely concerning their fears
7. Anti-anxiety medications

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DEPRESSION AND SUICIDE

1. Evaluate the causes of depression.
2. Anti-depressant medications
3. Encourage the person to set short-term goals
4. Encourage them to express their feelings
5. Validate their value as a person
6. Encourage family and friends to interact regularly with person
7. Encourage them to express reasons for any anger
8. Encourage them to do something meaningful for another person
9. Observe for signs of suicide
10. Remove objects that may prove lethal
11. Ask the individual if they are thinking about killing themselves

MANIPULATION AND DEPENDENCY

1. Focus on the person's behavior
2. Develop a set of expectations with the individual
3. Discuss the situation regarding manipulation and dependency
4. Encourage the person to gradually become more independent
5. Organize the care you give the person
6. Try to engage the same person or persons on a regular basis
7. Encourage the person to explore their feelings

LOSS OF SEXUAL INTIMACY

1. Encourage the person to talk about his/her concerns
2. Encourage the person to discuss the meaning of sex for him/her
3. Encourage alternative techniques
4. Offer privacy
5. Encourage closeness and touching with the sexual partner

CAREGIVER FATIGUE

1. Encourage the person to discuss the fact he/she is fatigued
2. Normalize the presence of fatigue
3. Encourage the use of respite care
4. Encourage alternative experiences such as taking in a movie, going shopping, out to dinner, a week end off etc. on a regular basis
5. Encourage eating a well-balanced diet, and sleeping adequate hours
6. Minimize the use of alcohol, tobacco or prescription drugs or street drugs
7. Encourage family or friends to assume some of the caregiving

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ASSUMPTIONS AND PRINCIPLES OF HOSPICE CARE

GENERAL ASSUMPTIONS

1. Care of the dying is a process involving the patient, family, and caregivers.
2. The problems of the patient and family facing the terminal illness include a wide variety of issues - physical, psychological, legal, social, spiritual, economic, and interpersonal.
3. Dying tends to produce a feeling of isolation.
4. The dying person and significant others need to experience the personal and loving concern of those taking care of them.
5. Health care services in the community often lack coordination
6. A supportive physical environment contributes to the sense of well-being of patients, of families, and of caregivers.

PATIENT ORIENTED ASSUMPTIONS AND PRINCIPLES

1. There are patients for whom aggressive curative treatment becomes increasingly inappropriate.
2. The symptoms and pain of terminal disease can be controlled.
3. Patients' need over time may and will change.
4. Care is most effective when the patient's lifestyle is maintained and philosophy of life is respected.
5. Patients often suffer from helplessness, weakness, isolation, and loneliness.
6. Patients must be treated as if capable of understanding or making decisions.
7. The varied problems and anxieties associated with terminal illness can occur at any time of the day or night.

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CARE OF THE DYING AND THE FAMILY

1. Care is usually directed toward the patient. In terminal illness the family must be the unit of care.
2. The course of the terminal illness involves a series of clinical and personal decisions.
3. Many people do not know what the process of dying involves.
4. The patient and family need the opportunity for privacy and being together.
5. Complexity of treatment and time consuming procedures can cause disruption for the patient and family.
6. Patients and families facing death frequently experience a search for the meaning of their life, making the provision for spiritual support is essential.
7. Survivors are at risk emotionally and physically during the death of the person and over the period of bereavement.

HOSPICE STAFF ORIENTED ASSUMPTIONS

1. The growing body of knowledge in symptoms and pain control, patient and family centered care, and other aspects of the care of the terminally ill is now readily available.
2. Effective and meaningful terminal care presupposes an emotional investment on the part of the staff.
3. Emotional commitment to effective and meaningful care will often result in emotional exhaustion.
4. There are supportive and healthy methods of maintaining physical and emotional health offered regularly at Hospice.
5. The nurse assumes a very valued and privileged role in helping persons' die well and supporting the loved one in a meaningful way during the grieving period.

COMMUNICATION WITH THE DYING PERSON AND FAMILY

1. Relate to the individual and family with all that is uniquely yourself.
2. Be open and honest in communication and behavior.
3. Listen with an unbiased mind to what the patient and family are telling you. Observe feelings and behaviors that accompany words.
4. Arrange to spend time with the dying person and family.
5. Respect the wishes of the dying person.
6. Show concern through the use of touch as appropriate.
7. Encourage the person to express feelings and emotions such as anger, sadness, denial, shame, ambivalence etc.
8. Offer spiritual support.
9. Refrain from categorizing the dying and grieving into stages. Allow the person to be and respond in their own uniqueness.
10. Do not destroy all hope.
11. Arrange respite time for the family or caregiver.
12. Suggest the use of community resources.
13. Arrange for supportive therapy such as relaxation, music, art, or massage.
14. Respect silence.
15. Become comfortable using the words dying and death rather than such words as passed away or expired.
16. Realize that the grieving process takes time, months, and years.
17. Encourage the family to maintain adequate nutrition, to exercise, to take some time away for themselves to cope in a more healthy manner.

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18. Encourage the use of reminiscing both for the dying person and the significant others.

19. Become knowledgeable about the normal processes of dying and grieving.

20. Become comfortable with allowing the dying and grieving person to cry. You cannot take away the hurt but your healing, caring, presence can make a significant difference in the death and grieving experience.

The privilege of being a significant person to others in dying and grief touches us as few other human experiences. The rewards can be a unique appreciation for life, love, and beauty of each person and the world around us.

A MEMORIAL TRIBUTE TO JULIA BROWN R.N.

"YOU ARE A KALEIDOSCOPE OF MEMORIES
IN LIFE AS IN DEATH YOU ARE STILL A TEACHER
YOU HAVE TAUGHT US TO REACH DEEP DOWN INTO
OUT DARKEST AREAS AND REMIND US OF THE
CARE AND KINDNESS WITHIN, ALSO TO REMIND
US THAT THERE IS PAIN IN LOOSING YOU,
BUT NOT TO FORGET THE JOY OF HAVING LOVED YOU
YOU HAVE SHOWED US YOUR HONESTY AND YOU HAVE
ENABLED ALL OF US TO SEE OUR OWN
ON THE ROLLER COASTER OF LIFE YOU HAVE BEEN
THERE FOR THE SMOOTH RIDE AS WELL AS GUIDED US
THROUGH THE ROUGHER RIDE--AND WE ARE ALL THE
BETTER FOR HAVING HAD SHARED THE RIDE"

SADLY MISSED BY ALL

WE WILL NEVER FORGET YOU

THE NURSING STAFF

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OBJECTIVES FOR S.P.J.C. NURSING STUDENT HOSPICE EXPERIENCE

Students assigned for a Hospice clinical experience will be assigned to accompany a Hospice nurse on visits to patients and family in the home setting. Coordinate your time to match that of the nurse.

1. Attend a class on the hospice philosophy of care for the terminally ill, and significant others, the specific roles of the nurse, the interdisciplinary team approach and how hospice care differs from home health care.
2. Read the hospice handout materials.
3. Call the designated hospice nurse at least two days prior to the experience to make specific arrangements.
4. Listen to a report of the patient and family given by the nurse prior to visiting the patient.
5. Review the interdisciplinary patient/family care approach including the physical, psychosocial, and spiritual aspects.
6. Review unique Hospice therapeutic approaches to pain and symptom control.
7. Discuss the patient/family and or caregiver strength and weaknesses in dealing with the loss experience.
8. Accompany the hospice nurse, visit the patient/family and interact with them as appropriate.
9. Observe the interactions and therapeutic communication used with the patient/family, the hospice nurse and other professionals.
10. Discuss the major nursing diagnoses, therapeutic interventions, and treatment outcomes. (After the visit)
11. Discuss the coping mechanisms used by the nurse when caring for the terminally ill and their significant others. (After the visit)
12. Attend an interdisciplinary team conference when possible.
13. Attend Hospice in-service classes when possible.
14. Complete the Hospice Home Visit Focus Sheet (Appendix 1) for four patient/family visits made with the hospice nurse.
15. Complete the evaluation form and reaction statement regarding this experience and hand it in to your instructor.

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16. Share your experiences at Hospice the following week in post conference.

17. Maintain professional confidentiality regarding the clinical experience at Hospice.

GUIDELINES FOR SPJC NURSING STUDENT HOSPICE CLINICAL EXPERIENCE

1. Wear your street clothes, dress presentably; no shorts, jeans or beach attire. Do not wear perfume or cologne. Please wear you SPJC I.D. Tag.
2. It is not appropriate to make any personal arrangements with the patients or family regarding future employment, purchasing of items or social engagements.
3. Complete a confidentiality form required by the agency.
4. Students are <u>never</u> to ride with the clinical associate since this is not permitted by college policy. <u>Drive your own car</u>.
5. You are responsible for arranging with you clinical associate 2-3 days ahead of time, where to meet him or her, the time you are to meet, and any other pertinent information you need for the next day. You are expected to be on time as arranged.
6. If you are unable to attend this clinical experience for any reason you are to call the college early in the morning of the day and leave a message for your instructor. Also call your nurse regarding your absence.
7. Policies and Procedures in the <u>Student Handbook</u> apply to the Hospice clinical experience.

ASK QUESTIONS AND INTERACT WITH YOUR NURSE, THE CLIENT, AND FAMILY

MAY THIS EXPERIENCE BE A MEMORABLE, EXCITING, AND FANTASTIC LEARNING EXPERIENCE FOR YOU

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HOSPICE HOME VISIT FOCUS SHEET

Patient's initials _____ Age _____ Length of illness _____

Disease process _____

Patient's physical status _____

Patient's psychosocial status _____

Significant others: (family caregivers and support persons) initials, age, physical and psychosocial status _____

Patient and caregiver's strengths _____

Psychosocial problems and interventions used _____

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Physical problems and interventions used with a focus on symptom and pain control

Describe involvement of others from the interdisciplinary team

Evaluation of learning experience (be specific and use the back of this sheet as necessary)

STUDENT EVALUATION OF HOSPICE CARE EXPERIENCE AND CLINICAL ASSOCIATE

Directions: Complete this form at the end of the clinical experience using the following ratings: Score 1 = Poor, 2 = Fair, 3 = Average, 4 = Above average, 5 = Excellent, NA = No Answer

	Rating					
	1	2	3	4	5	NA
THE CLINICAL ASSOCIATE						
1. Seemed eager to teach student.						
2. Was a _____ role model.						
3. Gave the student a report on the specific needs and approaches to patient/family from a interdisciplinary approach prior to seeing them in the home.						
4. Demonstrated the use of therapeutic approaches to patient care.						
5. Discussed unique hospice approaches to pain and symptom control.						
6. Communicated effectively with patient and family focusing on special needs of the dying and grieving.						
7. Encouraged student to participate in giving nursing care to the patient/family.						
8. Communicated effectively with the student.						
9. Taught the student clinical nursing care and charting.						
10. Explained therapeutic psychosocial approaches used with the dying patient and grieving family.						
11. Answered questions and encouraged thinking and problem solving.						
12. Discussed client and family outcomes after the visit.						

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13. Provided feedback regarding student's performance.						
14. Conveyed an attitude of acceptance and empathy and support toward the client/family.						
15. Discussed personal coping strategies						
HOSPICE CLINICAL EXPERIENCE						
1. The orientation to this experience was:						
2. In helping me evaluate my attitudes toward dying and grief it was:						
3. In helping me better understand the needs of the dying and grieving it was:						
4. In helping me better care for the dying and grieving it was:						

5. Specifically describe your overall reaction to this clinical experience.

6. What did you like the best about this experience?

7. What did you like least about this experience?

8. How would you change this experience?

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NUR IV

NUR 2732 - 2732L

HOME/HEALTH CARE

THEORY AND CLINICAL

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SCHOOL YEAR 1995-96

ST. PETERSBURG JUNIOR COLLEGE NURSING PROGRAM
NUR 2732-2732L - NURSING IV

HOME HEALTH NURSING THEORY

UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
1. Describe the meaning of home health care.	1. Definition of Home Health Care	1. Read Appendix 2 and 5. Berger and Williams, pp. 178-188.
2. Discuss the historical perspective of home health care.	2. Historical Perspective a. 1700 's b. 1800's c. 1900's d. Twentieth century	2. Read Appendix 2.
3. Explain the coverages for home health services under Medicare and Medicaid, and third party payers.	3. Coverage of Services a. Medicare b. Medicaid c. CHAMPUS d. Private health insurance	3. Read Appendix 2.
4. Discuss the eligibility requirements for home health services.	4. Eligibility Requirements	4. Read Appendix 2.
5. Describe the types of home health agencies.	5. Types of Home Health Agencies a. Public b. Non-profit	5. Read Appendix 2.

UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
	c. Proprietary d. Institutional based e. Primary home health f. Parent home health	
6. Delineate between the coverages of services.	6. Coverage of Services	6. Read Appendices 1, 2, and 5.
7. Compare and contrast the responsibilities between the various personnel.	7. Personnel a. Physician b. Registered nurse c. Licensed practical nurse d. Therapists e. Medical social worker f. Home health aide	7. Appendix 4.
8. Discuss the roles and functions of the home health care nurse	8. Roles and Functions of HHC Nurse a. Assessment, planning, intervention, evaluation b. Performing procedures c. Teaching client and family	8. Read Appendix 3.

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UNIT OBJECTIVES	CONTENT OUTLINE	ACTIVITIES
	d. Developing the nursing care plan e. Coordinating services of other professionals and paraprofessionals	
9. Analyze a journal article relating to home health care nursing.	9. Roles of the Nurse in Home Health Care a. Medical/surgical nursing b. High tech nursing c. Care of children d. Care of mother and baby e. Mental health nursing	9. Read and analyze a journal article related to HHC nursing. List the article title, author, journal, a summary, and a reaction statement to the article. Caring is a home health nursing journal in library. Hand in to instructor

Home Care
Patient Focused Processes

5

NUH/NUR2732/HOMEHEALTH.NUH
July 14 '95

HOME HEALTH CARE NURSING

Home health care nursing is administering of quality nursing care to acute or chronically ill clients of all ages in the home setting on an intermittent or part-time basis while integrating community health nursing principles that focus on the environmental, psychosocial, economic, cultural, and personal health factors that affect an individual's and family's health status.

1. Unique field of practice with focuses on care in the home, both chronic and acute.

2. Requires synthesis of community health principles with theory and practice of medical-surgical, maternal child, and mental health.

3. Client is the individual, family, and or significant others.

4. It is complex in nature since it refers to the family, home, and community.

5. Professional care requires nurses to understand how the environment, psychosocial, economic, cultural, and personal health factors affect the client's illness and his or her ability to meet the goals outlined in the plan of care

6. A variety of services are provided:

   a. Nursing care: nurse practitioner, registered nurse, licensed practical nurse, nurse practitioner care
   b. Therapies: physical therapy, occupational therapy, speech therapy respiratory therapy
   c. Social worker
   d. Dietitians
   e. Paraprofessionals: home health aide, housekeeping
   f. Medical equipment services
   g. Pediatric services
   h. Mental health services
   i. Comprehensive I.V. therapy services
   j. Adult services
   k. Rehabilitative/restorative services

Historical Perspective

Home health care has it's roots in the 1700's when religious orders of women and men made home visits to the sick poor. In 1796, the first home care in the United States was provided through the Boston Dispensary. In the 1800's home care nurses were call "district nurses" a title used by Florence Nightingale. Later visiting nurses caring for the sick in homes were eventually known as The Visiting Nurses Association. Graduate nurses in California who cared for the sick and poor were first called public health nurses in 1898.

Medicare and Medicaid was first establishes in 1965. Under Medicare, the first federally funded home health care program was instituted and home health care agencies became certified to deliver services in the home.

Medicare has parts A and B.

1. Part A. reimburses hospital or post hospital expenses that are funded by Social Security moneys.

2. Part B covers physician's care, laboratory costs, medical equipment and supplies, plus physical, occupational and speech therapy, social worker, and other services and is paid for through monthly payments made by the recipient.

Home health care has been impacted by the initiation of Diagnostic Related groupings (DRG) in which hospitals are reimbursed a predetermined amount of money for patient care based upon the patient's diagnosis. Patients are often discharged from the hospital earlier than was usual since it results in greater financial gain to the hospital. Home health care then assumes the responsibility for the care of many patients in their home.

Rice (1992) believes home health care will continue to evolve and be influenced by:

1. the increasing level of acuity of patients cared for in the home.

2. the increasing use of medical technology in the home setting.

3. the increasing diversity of patient problems that arise when managing health care needs in the home setting.

4. the continuous restructuring of health care services due to changes in the economic and social arenas.

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Manager of Care

1. The home health nurse is the manager of patient care through the use of the processes of planning, organizing, coordinating, and monitoring the needed services and resources required by the client and family's health care needs. Through the use of health care resources and social services, the nurse gives quality health care, through coordination of multiple services, maintains cost containment, and increases the quality of life for the client and family. (Stanhope, M. and Lancaster, J. 1992) (See Appendix 3)

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2. Rice, (1992) identifies universal clinical factors that influence the management of health care in the home environment:

   a. The cultural heritage and age-related factors that vary with each person.
   b. Psychobiological factors (physiological, mental, spiritual, and emotional factors).
   c. How the disease manifests itself (acute, chronic, long-term, short-term, congenital, or terminal).
   d. Factors relating to the environment and socioeconomic issues (availability of food, housing, medical supplies, support systems, and accessibility to the health care system).

Roles and Functions of the Home Health Care Nurse

I. Provide quality health care through a holistic approach by:

   a. assessment, nursing diagnosis, planning, implementing client care, and evaluation of the care given.
   b. performing procedures.
   c. monitoring and supporting the progress of the client, family, and Caregiver.
   d. facilitating communication.
   e. health-promotion to diminish the disability, and maintain quality of life.
   f. facilitating continuity of care.
   g. teaching the client, family and/or caregivers to encourage self-care activities.
   h. developing Nursing Care Plan with short- and long-term goals.
   i. being knowledgeable about third party payers such as Medicare, Medicaid, CHAMPUS, and private health insurance. The nurse is knowledgeable about the
      (1) the extent of the comprehensive coverage
      (2) the number of visits needed by the client per week by the disciplines involved, these decrease as the client improves and him/her or the family can assume care of the client
   j. coordinate services with other professionals and paraprofessionals in a multidisciplinary approach:
      (1) needs assessment
      (2) prioritizing problems
      (3) planning care
      (4) implementing care
      (5) maintaining contact with the physician
      (6) keeping the case coordinator up to date
      (7) determining the financial coverage
      (8) determining duration of care
      (9) community resources coordination
      (10) client advocacy, access and assistance with financial matters

(II) monitoring technical and instrumental patient care

Eligibility for Home Health Care

1. To be eligible for home health care services the patient must meet the following criteria

   a. homebound status.
   b. need part-time intermittent skilled services.
   c. the person is eligible for medicare benefits.
   d. the agency providing service is a licensed agency.
   e the services are reasonable and necessary.
   f. the services are ordered by a physician.
   g. the patient is under the care of a physician, who will sign the plan of care.

Types of Home Health Care Agencies

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1. Public agency, is an agency operated by a State or local government.

2. Proprietary agency is a private profit-making agency licensed by the State.

3. Non-profit is an agency owned and operated not to make a profit but to rechannel any profits back into the operation of the organization. It is exempt from Federal income taxation.

4. Institution based: is a separate department within an institution such as a hospital and can be either not for profit, for profit.

5. Primary home health agency is the agency responsible for the services furnished to patients and for implementation of the plan of care.

6. Parent home health agency is the agency that develops and maintains administrative controls of subunits and/or branch offices.

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THE NURSING PROCESS AND CASE MANAGEMENT*

NURSING PROCESS	CASE MANAGEMENT PROCESS	ACTIVITIES INVOLVED
Assessment	Caselinding and Assessment	Develop networks with target population; seek referrals; apply screening tools according to program goals and objectives; apply comprehensive assessment methods; perform interdisciplinary, family, and client conferences
Diagnosis	Problem Identification	Determine conclusion based on assessment; use interdisciplinary team
Planning	Problem Prioritizing	Validate and prioritize problems with all participants; develop activities, time-frames, and options; gain client's consent to implement plan; have client choose options
Implementation	Client Advocacy	Contact providers; negotiate services and prices; coordinate service delivery; monitor for changes in client or service status
Evaluation	Reassessment	Examine outcomes against goals; examine needs against service; examine costs, examine satisfaction of client, providers, and case manager

* Stanhope, M. and Lancaster, J. (1992). Community Health Nursing: Process and Practice for Promoting Health. (3rd ed.) St. Louis. Mosby-Year Book.

HCFA FEDERAL REGISTER AND HIM-II: DUTIES OF HOME HEALTH PERSONNEL*

Duties of the physician. The physician reviews and directs the plan of care. The plan of care is reviewed by the attending physician as often as the severity of the patient's condition requires, but at least once every 62 days.

Duties of the registered nurse. The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, provides those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

Duties of the therapist. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of care (revising as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in in-service programs.

Duties of the medical social worker. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of care, prepares clinical and progress notes, works with the family, uses appropriate community resources, participates in discharge planning and in-service programs, and acts as a consultant to other agency personnel.

Duties of the home health aide. The certified home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. The certified home health aide participates in observation, reporting and documentation of patient status and the care or service furnished; reads and records temperature, pulse and respiration; uses basic infection control procedures; is knowledgeable of basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; maintains a clean, safe and healthy environment; recognizes emergencies and knowledge of emergency procedures; is knowledgeable of the physical, emotional and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property; utilizes appropriate and safe techniques in personal hygiene and grooming that include a) bed bath, b) sponge, tub or shower bath, c) shampoo, sink, tub or bed, d) nail and skin care, e) oral hygiene, and f) toileting and elimination; uses safe transfer techniques and ambulation; uses normal range of motion and positioning; is knowledgeable of adequate nutrition and fluid intake; and performs any other task that the HHA may choose to have the home health aide perform.

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* Health Care Financing Administration: Federal Register 42 CFR Part 484, 54(155): 33354-33373, 1989, and Home Health Insurance Manual, Pub. No. 11-Rev. 229, 1990, Washington, D.C., U.S. Department of Health and Human Services.

HIM-II-COVERAGE OF SERVICES*

Home Health Agency

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary non-profit health agency may qualify by:

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

* From Health Care Financing Administration: *Health insurance manual*, Pub. No 11-Rev 229, U.S. Department of Health and Human Services, Washington, D.C., 1990, item 200:13.

S.P.J.C. NURSING STUDENT
HOME HEALTH CLINICAL EXPERIENCE

OBJECTIVES

Students assigned for a Home Health Care clinical experience will be assigned to accompany a home health nurse on visits to patients and family in the home setting. Coordinate your time to match that of the nurse.

1. Attend a class on the home health philosophy of care for the patient and significant others, and the specific roles of the nurse.
2. Read the handouts related to Home Health Care and the Home Health packet.
3. Call the designated home health nurse at least 2 days prior to visiting the patients to arrange for the experience.
4. Listen to a report of the patient and family given by the nurse prior to visiting the patient's home.
5. Review the patient's care plan.
6. Observe the care given to the patient by the clinical associate.
7. Participate in giving care to the patient by assessing the patient, planning the care, intervening, doing procedures, and evaluating the care given.
8. Observe interactions and therapeutic communication used with the patient/family.
9. Communicate with the patient/family using therapeutic communication skills and document care as appropriate.
10. Teach the patient and family how to better understand their health problems and how to manage them and their medications.
11. Discuss the major nursing diagnoses, therapeutic interventions, and treatment outcomes. (After the visit)
12. Complete the Home Health Care Focus Sheet for four patient's visits made with the home health care nurse.
13. Access community resources, under the direction of the nurse, in assisting with the care of the patient.
14. Identify adaptations to patient care in this environment as compared to nursing care given in an institutional setting.

15. Discuss the coping skills used by the nurse in caring for patients in the home setting.

16. Complete the evaluation form and reaction statement regarding this experience and hand it in to you Instructor.

17. Share your experiences in Home Health Care the following week in post conference.

18. Maintain professional confidentiality regarding the clinical experience with home health care.

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HOME HEALTH VISIT FOCUS SHEET

Patient's Initials _____ Age _____ Length of care _____

Diagnosis _____

Describe the patient's current physical condition _____

Describe the patient's psychological and social status _____

Describe the family and or significant others _____

Identify specific patient problems, physical and psychosocial, and specific interventions _____

Identify patient's strengths _____

_____

_____

Identify the medications taken by the patient _____

_____

_____

Discuss the health teaching that was done _____

_____

_____

Describe adaptive techniques used in giving patient care _____

_____

_____

Evaluate this learning experience (be specific and use the back of the sheet if necessary) _____

_____

_____

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STUDENT'S EVALUATION OF HOME HEALTH CARE EXPERIENCE AND CLINICAL ASSOCIATE

Directions: Complete this form at the end of the clinical experience using the following ratings: Score 1 = Poor, 2 = Fair, 3 = Average, 4 = Above average, 5 = Excellent, NA = No Answer

THE CLINICAL ASSOCIATE	Rating					
	1	2	3	4	5	NA
1. Arranged to meet student at specified place before seeing patient.						
2. Seemed eager to teach student.						
3. Was a_____ role model.						
4. Gave the student a report on the specific needs and approaches to patient/family from a interdisciplinary approach prior to seeing them in the home.						
5. Demonstrated the use of therapeutic approaches to patient care.						
6. Communicated effectively with patient and family.						
7. Encouraged student to participate in giving nursing care to the patient/family.						
8. Communicated effectively with the student.						
9. Taught the student clinical nursing care.						
10. Taught the student how to chart.						
11. Explained therapeutic psychosocial approaches used with patient and family.						
12. Answered questions and encouraged thinking and problem solving.						
13. Discussed client and family outcomes after the visit.						
14. Provided feedback regarding student's performance.						

15. Conveyed an attitude of acceptance, empathy and support toward the client/family.						
16. Discussed personal coping strategies						

17. Specifically describe your overall reaction to this clinical experience.

18. What did you like the best about this experience?

19. What did you like least about this experience?

20. How would you change this experience?

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NUR IV

NUR 2732 - 2732L

CLINICAL EXPERIENCE IN COMMUNITY SETTINGS WITH MIDDLE-AGED AND OLDER ADULTS

SCHOOL YEAR 1995-96

ST. PETERSBURG JUNIOR COLLEGE
NURSING PROGRAM
NUR 2732-NUR 2732L - NURSING IV

CLINICAL EXPERIENCE IN COMMUNITY SETTINGS FOCUSING ON MIDDLE-AGED AND OLDER ADULTS

"WITH ONE MIND WE ADDRESS OUR ACKNOWLEDGMENT, RESPECT, AND GRATEFULNESS TO ALL THE SACRED CYCLE OF LIFE. WE, AS HUMANS, MUST REMEMBER TO BE HUMBLE AND ACKNOWLEDGE THE GIFTS WE USE SO FREELY IN OUR DAILY LIVES"
Audrey Shenandoah.....Onondaga Indian

A vast array of community settings are available in Pinellas County for middle-aged and older adults. They range from Adult Congregate Living Facilities (ACLF's) to community recreation centers. Some examples are Senior Centers such as the Sunshine Center, and the Enoch Davis Center, Adult Day Care, Congregate Meal Sites, Church Programs, Hospital Programs for Seniors, Community Care for the Elderly, and others offer recreational, educational, nutritional, health and wellness programs for individuals and groups. As a nurse manager, your knowledge of these programs and how to access their services is essential as you assist older adults and their family in planning an optimal living experience for them.

The nurse's primary role is to develop a positive relationship with the older person, assess their needs, and effectively teach them how to stay well, prevent accidents, and how to access the health care system.

The multiple health problems common among older adults often necessitates the regular use of several types of medications. It is estimated about ten different medications are prescribed for them each year, often numbering twelve to twenty pills per day. The number of drug reactions and interactions is high in this age group because of slower processing in the body resulting in more toxic effects than in younger persons. Continued assessment of the drugs prescribed and the individual's understanding of them is a major role of the nurse in the care of this age group. Through assessment and teaching we can make a major difference in the maintenance of health and keeping people well.

COMMUNITY EXPERIENCE FACT SHEET

The student will select a community agency they wish to visit from a listing of community programs that serve middle-aged and older adults. The student will call and make an appointment with a manager of the program and explain the following purposes of the visit:

a. To interview the manager using (Appendix 1).

b To be oriented to the program and its services.

c To interview an older person focusing on:

(1) personal history.
(2) health history.
(3) drug assessment.
(4) develop a plan for teaching.

DIRECTIONS

1. Students will arrive at the agreed upon time and place. If unable to do so call ahead of time and inform the individual you are not able to be there and make an appointment for another time.

2. Wear presentable street clothes (no jeans, shorts, beach clothes, or perfume). Wear you SPJC name tag.

3. Introduce yourself and describe the purpose and learning activities of the visit.

4. Request that an older client be assigned to you to interview on the second visit and arrange a time to do the interview. Inform the manager when you arrive to do the client interview and when you leave.

5. Thank the older adult and manager for their time and contribution to you learning experience.

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INTERVIEW WITH A PROGRAM MANAGER IN A SETTING THAT SERVES OLDER ADULTS

Name of the Agency: _____

Initials of person being interviewed: _____

What is the role of the manager being interviewed: _____

_____

_____

_____

Describe the services offered to older adults in this setting; (Attach a brochure explaining the services is possible.): _____

_____

_____

_____

_____

Eligibility for services: _____

_____

_____

Cost of the services: _____ Hours open: _____

Describe the type of older persons being served. _____

_____

_____

Describe the positive aspect of the manager's role with elders. _____

_____

_____

_____

Describe the challenges and problem areas experienced by older adults being served. _____

_____

_____

_____

What advise do you have for me as a nursing student to be more effective in working with older adults? _____

_____

_____

_____

_____

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TEACHING MIDDLE-AGED AND OLDER ADULTS

I. Factors that influence learning in the older adult.

A. Physical Factors

Some of the physical changes that occur with age affect the older adult's ability to learn as quickly or as well as a younger person. Performing new skills may also be impeded. Certain changes that occur in the musculoskeletal and nervous systems result in a slowing down of psychomotor activity. Therefore, a longer time is needed for the older adult to move about and translate commands into action.

Health conditions such as arthritis, Parkinson's disease, fractures, and generalized decreased endurance make it difficult to sit for a period of time. Persons with organic brain disease and arteriosclerosis may perform less well on intellectual and psychomotor tasks. Decreased blood cholesterol levels have been associated with improved learning. Knowledge of Physical changes in the sensory system is of primary importance when teaching older adults.

Vision - Sharpness of vision is decreased as well as accommodation, which is the ability to focus at different distances. The pupil decreases in size, the lens becomes less transparent, and yellow cataracts are a common occurrence. The colors orange, red, and yellow are more easily perceived than blue-greens or violet.

Audition - Hearing, is also impaired with age. Presbycusis is a common problem in which higher frequencies of sound are usually less audible. Speech sounds are not readily distinguished from other sounds which makes it difficult to follow a normal conversation.

Gustation, Touch, Vibration, and Olfaction - All of the above senses experience change with age. Diminished taste, touch, smell and vibration occur but at varying ages. However, these do not interfere appreciably with learning.

B. Psychological Factors

Psychological changes of age are most important in relation to learning. The primary ability to learn shows a little decrease with age but motivation, physical disease, set perception, and attention may influence learning in the older adult. Continued mental stimulation and interest in new ideas is a prime motivation in facilitating learning; lack of confidence in the ability to learn can be the greatest hindrance.

Certain psychological changes may slow down the learning process. The older learner solves problems using what he already knows and is less likely to change. This pattern is affected by the years of formal education, the length of time since he attended classes, and the level of intelligence. Intelligence tests reveal that the IQ may drop and that performance decreases on psychomotor skills, especially speed in performance, and the ability to integrate information. Verbal abilities and information accrued over the years usually remains intact.

Aging individuals are slower in receiving information into the sensory receptors, slower in processing it through the nervous system, and slower in responding to information.

Memory, especially of recent events, may decrease with age for some older people. Others show no decline into old age. The decline may be due to a lack of interest or ability to concentrate on the central meaning and neglect the less important features. Older items have been rehearsed often over the years, whereas recent items have not been reinforced as often. Psychopathology may also contribute to memory loss and extraneous and disruptive activity and noise may interfere with the ability to remember recent events.

Individual differences in the older adult are common in regard to reaction time. However, a general decline in reaction time is noted with aging. Older persons learn best when they are permitted to pace themselves rather than be forced into a preset or rapid pace. Maturation is of prime importance if learning is to occur. The task to be learned must have some relevance and meaning for the older person. Decreasing the amount of irrelevant information and simplifying tasks enhances the amount of information learned.

Being aware of fears and concerns is especially important as well as assessing the psychological status before the teaching is begun.

C. Sociological Factors

The social institutions and their affect on people may also influence the manner in which the older adult learns.

Assuming various roles in society contributes to self-identity and worth. Retirement results in role changes which in turn may decrease the individual's sense of self-worth and inhibit and interest in learning.

Cultural and religious differences in individuals must be taken into consideration also. New ideas are absorbed and accepted if they are not opposed to the values and beliefs of a group. Differences in language can be a major impediment to understanding what is taught. Communication includes the choice of words that are basically understood by both the teacher and the learner. Economic deficit may affect social life and the standard of living. Learning, however, may increase knowledge of needed community resources, wise buying, and self protection. Chronic health problems increase with age; therefore, preventive health care, managing with a disease and identifying the presence of illness is a most important area of learning for the older adult.

II. Teaching Techniques

A. Setting

The physical surroundings may enhance or inhibit learning. Comfortable chairs placed informally in a room that is pleasantly decorated, lighted, and has proper temperature control contributes to the learning process. Extraneous visual or auditory stimuli interfere with the learning process. Bathroom facilities should be readily available to the group; accessibility of the classroom and the lack of impediments such as stairs should also be considered.

B. Learning Aides

Many types of aides are available to facilitate learning. These aides should also be selected to meet the individual needs of each student. Learning may take place individually or in groups.

Individual teaching can be provided through a variety of methods. The most commonly used method is one-to-one instruction. When this type of instruction is given, the teacher should face the learner and be on the same level. Eye-to-eye contact, speaking in tones that are audible, and showing a friendly interest and concern also facilitates the learning process. Many types of teaching aides may be used in this setting.

The use of teaching machines is another method of learning. Since these machines may cause some fear among older adults, they should be taught how to use them and a return demonstration given before they are used. Active involvement in learning is possible with this method of instruction, and material is presented in logical sequence. However, the teacher should obtain feedback from and provide reinforcement for the learner at periodic intervals.

Programmed instruction is a third type of individual instruction and provides a slow, carefully planned sequence of concepts with opportunity for feedback.

Group instruction offers support and security to the adult learner. Creating a pleasant, nonthreatening atmosphere where competition and criticism are absent promotes participation and learning. The learners should feel free to ask questions and receive appropriate compliments or comments.

Since adults are problem-oriented, they respond better to concrete examples than to detailed theory. Relating information from experience and using individual talents provides relevancy.

Learning goals should be developed by the instructor and learner with short-term goals as achievable points along the way to the long-term, or overall goal. Involvement in the learning process is crucial to maintain interest and cooperation. Effective use of the time provided may reduce resentfulness and compensate for inflexibility.

Motivation may be a crucial factor as to whether learning is achieved or not. Positive reinforcement suited to each learner's interest, drives, and needs should be given throughout the learning period.

Pacing the presentation of new materials to meet the needs of the learner is imperative. New concepts should be given at a comfortable rate that permits understanding, assimilation, and application. A variety of teaching methods such as films, models, pictures, handouts, demonstrations, student reports, videotaping, filmstrips, discussion, lecture posters, photographs, creative experiences, and field trips facilitate understanding. Active participation in class offers the opportunity for clarification and the recapping of ideas.

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Since adults learn more slowly, the materials should be presented in writing and in logical sequence with one concept relating to the previous one. Smaller units of instruction will help to motivate the learner. Continued presentation of the same concept using different means may help to effect learning as well as return demonstrations and explorations by the learner. Errors should be ignored and no sarcasm or ridicule is acceptable. Concentrate on the principle that the older adult can learn, and accent the positive.

Health teaching should be started early with the content given slowly with much repetition and feedback. Breaks should be frequent and refreshments provided, if possible. At the break time, social interaction, group identification, cohesiveness, and mutual support develop.

The length of the class should be determined by the needs of the group; an all day session may unduly tax the learners and some may even fall asleep. The hour the class is held should also be considered for many older persons find it difficult to drive in the dark and others are accustomed to an afternoon rest period. Individuals learn best when they are not concerned about illnesses, the loss of a spouse, or other crucial problems. Some participants may "take over the class." This can be a delicate situation in which individual feelings may be hurt and others may become bored. Encouraging participation by others in the group, presenting a schedule of events, and advising that a talkative participant may help another student, may help resolve the problem.

C. Teaching Persons with Sensory Deficits

Persons who have sensory deficits present special problems to the instructor. The following are methods that may facilitate learning for these persons.

Vision - If the learners have glasses, they should be worn, properly fitted and clean; magnification may also facilitate sight. The light source should be strong, but not glaring and the students should not face the light. When using diagrams, visual aides or printed matter, large print with distinct figures in contrasting colors facilitates seeing. Orange, red, and yellow are more readily visible by the older adult. Typing should always be double spaced. When teaching skills such as urine testing, particular care should be given that colors can be differentiated.

Special recordings or tapes for partially sighted may be obtained in most states at minimal or no cost. A variety of books and newspapers are also available. Sitting near the instructor or source of information is also helpful.

Audition - To facilitate hearing, the pitch of the voice should be lowered. This also applies to the use of visual aides where the tone can be adjusted. A normal speaking tone should be used, avoiding distracting gestures. Extraneous noises should be eliminated, especially those sounds that are on the same pitch as the human voice. Speech should be slower and more distinct, and the learner should be near and facing the source of the sound. Being aware of the learner's reactions such as leaning forward, turning the good ear, cupping the ear or changing facial expressions may determine whether they are hearing or not. Solicit reactions as to whether you are speaking loudly enough. Stimulating the use of the other senses through visual materials and the use of touch and smell may also be helpful. When questions are asked, they should be repeated so the entire group benefits from the conversation. Every effort should be made to determine if all the learners are following what is being taught.

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If hearing aids are used, they should be in working order, and the batteries replaced at the required interval. Learning through the senses of touch, smell, and taste may be improved by increasing the source of the stimuli.

It is of utmost importance that each of the senses be stimulated for maximum learning to take place.

READ: Saxon, S.V. and M.J. Etten, (1994), "Teaching the Older Adult" in Physical Change and Aging. New York: Tireslas Press. (Book is on reserve in the library and in the stacks.)

DRUG ASSESSMENT

Initials _____ Age _____ Marital Status _____ Weight _____

Cigarette use _____ Alcohol use _____

Living Situation _____ Exercise (describe type and amount) _____ Diet _____

Describe family and/or significant others _____

Describe person's health status _____

Health Problems: (physical and mental):

Occupation:

Recreational activities:

1. Drug regimen (include all drugs, prescribed or over the counter, dosages and times ingested)
2. Analyze the drugs, possible interactions, and side effects experienced by the person or observed by you.
3. Assess the individuals knowledge of the drugs ingested and how they relate to the specific health problems and record.
4. Develop a plan for teaching and informing the individual about the drug, such as interactions with other drugs or food, side effects, and methods of ingesting the drugs. Include any other area of need you assessed in where there is a need to teach.

MEDICATION ASSESSMENT

DRUG	STRENGTH AND FREQUENCY	DRUG HALF-LIFE	DRUG ACTION	SIDE EFFECTS	INTERACTION WITH OTHER DRUGS, FOOD, AND ALCOHOL

Allergy History: Medication allergies: _____

Type of reaction: _____

When? _____ How many times? _____ How long? _____

Treatment: _____

Analysis and reaction of the experience. _____

TEACHING GUIDE

Initials _____ Age ___

Describe characteristics of the learned. Refer to Berger and Williams, pp. 666-671 and 676-677.

Identify problem area.

TEACHING PLAN

Refer to Berger and Williams, pp. 688-693.

OBJECTIVES	CONTENT	TEACHING/LEARNING ACTIVITIES/APPROACHES
1.		
2.		
3.		

STUDENT EVALUATION OF THE COMMUNITY EXPERIENCE OF OLDER ADULTS AND AGENCIES

DIRECTIONS: Complete this form at the end of the experience using the following ratings: Score 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent

Agency Name

	Rating					
	1	2	3	4	5	NA
1. The manager's description of her role was:						
2. The manager's description and brochure of agency services was:						
3. The tour of the agency was:						
4. The manager's discussion of the positive aspects of his/her role was:						
5. The manager's description of problems experienced by elders at this site was:						
6. The interview with the older adult was:						
7. Developing the teaching plan was:						
8. The experience in the community agency was:						
9. What did you like best about the experience?						
10. Suggestions for change.						
11. Your overall reaction to the experience. (Use back of sheet.)						

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NURSING PROGRAM
NUR 2732-2732L - NURSING IV

OBJECTIVES FOR THE CLINICAL ASSOCIATE

Objectives: Upon the completion of this orientation the participant will be able to:

1. Discuss the student's clinical objectives for this agency experience.
2. Define the focus, role, and responsibilities of the clinical associate.
3. Discuss the role and responsibilities of the student.
4. Relate principles of effective clinical teaching to the educational process between the clinical associate and the nursing student.
5. Apply the principles of adult learning in your role as a clinical associate.
6. Discuss potential feelings and reactions of student nurses to out placement nursing clinical experiences.
7. Compare and contrast methods of effective communication with student nurses and the SPJC Nursing faculty.
8. Demonstrate qualities of an effective clinical associate.
9. Evaluate student nurse clinical performance using the evaluation tool.

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OBJECTIVES FOR S.P.J.C. NURSING STUDENT HOSPICE EXPERIENCE

Students assigned for a Hospice clinical experience will be assigned to accompany a Hospice nurse on visits to patients and family in the home setting. Coordinate your time to match that of the nurse.

1. **Attend a class on the hospice philosophy of care for the terminally ill, and significant others, the specific roles of the nurse, the interdisciplinary team approach and how hospice care differs from home health care.**

2. **Read the hospice handout materials.**

3. **Call the designated hospice nurse at least two days prior to the experience to make specific arrangements.**

4. **Listen to a report of the patient and family given by the nurse prior to visiting the patient.**

5. **Review the interdisciplinary patient/family care approach including the physical, psychosocial, and spiritual aspects.**

6. **Review unique Hospice therapeutic approaches to pain and symptom control.**

7. **Discuss the patient/family and or caregiver strength and weaknesses in dealing with the loss experience.**

8. **Accompany the hospice nurse, visit the patient/family and interact with them as appropriate.**

9. **Observe the interactions and therapeutic communication used with the patient/family, the hospice nurse and other professionals.**

10. **Discuss the major nursing diagnoses, therapeutic interventions, and treatment outcomes. (After the visit)**

11. **Discuss the coping mechanisms used by the nurse when caring for the terminally ill and their significant others. (After the visit)**

12. **Attend an interdisciplinary team conference when possible.**

13. **Attend Hospice in-service classes when possible.**

14. **Complete the Hospice Home Visit Focus Sheet (Appendix 1) for four patient/family visits made with the hospice nurse.**

15. **Complete the evaluation form and reaction statement regarding this experience and hand it in to your Instructor.**

16. **Share your experiences at Hospice the following week in post conference.**

17. **Maintain professional confidentiality regarding the clinical experience at Hospice.**

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S.P.J.C. NURSING STUDENT
HOME HEALTH CLINICAL EXPERIENCE

OBJECTIVES

Students assigned for a Home Health Care clinical experience will be assigned to accompany a home health nurse on visits to patients and family in the home setting. Coordinate your time to match that of the nurse.

1. Attend a class on the home health philosophy of care for the patient and significant others, and the specific roles of the nurse.
2. Read the handouts related to Home Health Care and the Home Health packet.
3. Call the designated home health nurse at least 2 days prior to visiting the patients to arrange for the experience.
4. Listen to a report of the patient and family given by the nurse prior to visiting the patient's home.
5. Review the patient's care plan.
6. Observe the care given to the patient by the clinical associate.
7. Participate in giving care to the patient by assessing the patient, planning the care, intervening, doing procedures, and evaluating the care given.
8. Observe interactions and therapeutic communication used with the patient/family.
9. Communicate with the patient/family using therapeutic communication skills and document care as appropriate.
10. Teach the patient and family how to better understand their health problems and how to manage them and their medications.
11. Discuss the major nursing diagnoses, therapeutic interventions, and treatment outcomes. (After the visit)
12. Complete the Home Health Care Focus Sheet for four patient's visits made with the home health care nurse.
13. Access community resources, under the direction of the nurse, in assisting with the care of the patient.
14. Identify adaptations to patient care in this environment as compared to nursing care given in an institutional setting.
15. Discuss the coping skills used by the nurse in caring for patients in the home setting.
16. Complete the evaluation form and reaction statement regarding this experience and hand it in to you Instructor.
17. Share your experiences in Home Health Care the following week in post conference.

18. Maintain professional confidentiality regarding the clinical experience with home health care.

CRITERIA FOR THE SELECTION OF SPJC NURSING CLINICAL ASSOCIATES

1. One to three years clinical experience in the current clinical setting.
2. Excellent clinical practitioner.
3. Desire to assume the role of clinical associate.
4. Completion of the Clinical Associate Training Module.
5. Excellent communication skills.
6. Compassionate and caring attitude.
7. Recommendation by supervisor.
8. Excellent professional role model.

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QUALITIES OF A CLINICAL ASSOCIATE

Professional and Personal Insight

Has self-confidence.
Aware of own strengths, weaknesses, and ways to address them.
Excellent communication skills.
Understands how to facilitate communication.
Is able to identify verbal and nonverbal cues.
Is a good listener.
Possesses a nonthreatening and non-judgmental attitude.
Is responsible.
Is patient.

Leadership Abilities

Has a positive attitude.
Is enthusiastic.
Has a sense of humor.
Is flexible and well-organized.
Is assertive.
Serves as a professional role model.
Is respected by peers.

Teaching Skills

Is an advocate of the student.
Is knowledgeable of the subject being taught.
Has knowledge of adult teaching and learning principles.
Is objective and fair in evaluating student performance.

Theoretical and Clinical Skills

Has clinical experience in home health, hospice, and nursing related to the specific setting.
Is familiar with agency policies and procedures.
Is able to integrate educational and work values.
Mastery of nursing theory and clinical practice.
Knowledgeable about the use of community resources.
Is well-organized.
Knowledgeable regarding environmental, cultural, and socioeconomic issues relative to patient care.
Is an advocate for the patient/family.
Mastery of client/family teaching.

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WHAT IS A CLINICAL ASSOCIATE?

A clinically competent registered nurse who is formally paired with a novice nursing student for the specific purpose of clinical teaching. The clinical associate enhances the clinical competence of the student and assists in socializing the student into the new role of a nurse. This is accomplished by the clinical associate functioning as a role model, tutor, facilitator, coach, supervisor, and evaluator. Reality shock for the student is diminished since the clinical associate is present for continual guidance, consultation, and support.

FOCUS, ROLES, AND RESPONSIBILITIES OF THE CLINICAL ASSOCIATE

The clinical associate should volunteer to serve in the role of a clinical associate.

Student assignments to your clinical agency are made at the beginning of the semester. You will receive your student assignment from the education coordinator or other designated person.

Student's are to wear presentable street clothes and the identification tag from St. Petersburg Junior College. They are not to participate in this experience wearing unprofessional attire.

Students are to call you a few days prior to the clinical experience to arrange for a meeting place. Please return their call as soon as possible.

Meet student at the arranged place on time, if possible. THE STUDENT IS TO DRIVE HIS/HER OWN CAR AS YOU GO FROM PATIENT HOME TO PATIENT HOME, COLLEGE INSURANCE DOES NOT COVER THE STUDENT.

Give the student a thorough report on the patient and family prior to visiting them identifying specific strengths, problems, and interventions as they relate to physical, social, and emotional areas.

Introduce the student to the patient and family.

Function as a role model for the student assessing, intervening, and evaluating nursing care for the patient and family.

Teach the student, when possible and feasible, during the care of the patient and family.

Encourage the student to assume some of the responsibilities when possible such as doing client and family assessment, procedures, teaching, or giving patient care.

Teach the student how to complete paperwork on the client when possible.

Teach the student therapeutic communication approaches with the patient or family.

Following the visit, discuss the patient/family situation, nursing diagnoses, interventions, rationale, and outcomes with the student.

Answer student questions, encourage them to think and problem-solve.

Share your personal coping strategies with the student regarding the unique stresses of nursing in this setting.

The clinical associate retains the responsibility of the patient at all times.

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The clinical associate can retain or withdraw the student from the clinical setting or patient care according to her or his judgment. If you are withdrawing a student from the clinical setting first call the Nursing Department (341-3618) and then instruct the student to return to the SPJC nursing office to meet with an administrator.

The clinical associate is to notify the nursing department (341-3618) if the student is absent from the clinical experience.

The student is expected to maintain patient confidentiality.

Any violation regarding safety or confidentiality should be reported to the instructor coordinating the experience.

The clinical associate's evaluation of the student will be one component of the student's final clinical evaluation.

It is inappropriate for students to make any personal arrangement with the patient or family regarding future employment, purchasing of items, or social engagements.

Students carry their own malpractice insurance and are responsible for skills that have been successfully checked off by their Instructor.

Students carry a skills checkoff book for your reference.

If you do not currently carry malpractice insurance, you may consider doing so.

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STUDENT/CLINICAL ASSOCIATE RELATIONSHIP

The Relationship

Components which best facilitate learning:

1. Relaxed atmosphere leading to openness and student's willingness to share fears, concerns, areas of knowledge deficit as well as positive learning experiences. (Students are hesitant going to a patient's home and sometimes feel they are intruding on the patient/family and nurse's privacy. They may also be anxious if people are dying and grieving, not knowing what to do or say).

2. Sharing

   Self-disclosure, regarding your education, experience and person, helps facilitate student learning.

3. Caring

   Helps to bond the Clinical Associate and the student's increasing ability to share feelings and knowledge.

   Facilitates caring with patients.

   Creates in the student a sense of "belonging to the agency"

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SOME THOUGHTS ON TEACHING/LEARNING

"TELL ME AND I'LL FORGET. SHOW ME AND I MAY REMEMBER. INVOLVE ME AND I'LL UNDERSTAND" Native American quotation

WHAT IS LEARNING?

Learning results in the change of behavior, through experience, and is an ongoing process.

WHAT IS TEACHING?

The act of instructing, directing, showing, training, guiding, another human being in the learning process.

CHARACTERISTICS THAT INFLUENCE LEARNING

Characteristics of the learner are individual unique qualities or attributes of the individual that indicate the ability of the person to learn.

They also determine appropriate approaches to teaching the individual that are the most likely to be successful.

1. Self-concept as a learner
2. Past experiences with learning
3. Readiness or willingness to learn
4. Motivation to learn
5. Level of anxiety
6. Physical/emotional status
7. Ability to learn
8. Reading comprehension
9. Intactness of individual's sensory system
10. Ability to understand the spoken and written language being used

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PROFILE OF SPJC NURSING STUDENTS

SPJC Nursing students tend to be years beyond post high school age. Many have had other professions, and jobs. A considerable number of them already have associate, bachelors, or master's degrees in other areas and some have had their own businesses. A substantial number of them are parents, some single parents. All had nursing assistant training prior to coming into the nursing program.

PRINCIPLES OF ADULT LEARNING

Adults

Bring valid experiences to the learning situation

Have immediate needs and objectives

Need evidence of usefulness

Can identify own learning needs

Are responsible for own learning

Appreciate an informal atmosphere

May have negative experiences related to goals/situations

Must have a clear understanding of what is expected of them

Should be permitted to practice in a nonthreatening environment

Retain information better when practice and application is available shortly after information is acquired

Want feedback on their understanding/performance

May have short attention/retention ability due to "information overload" of learning experiences

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GUIDE TO EFFECTIVE CLINICAL TEACHING

Take some time to get to know your nursing student as a person, their needs, expectations, and competencies.

Be an excellent role model for the student. What you do, how you do it, and your interactions with others are powerful methods of clinical teaching. Your attitude toward nursing is important.

Create a climate of mutual respect that is nonthreatening by inviting the student to learn from you in this environment.

Encourage students to participate in their own learning, then learning is more relevant and meaningful.

Demonstrate clinical procedures and nursing actions, but then expect students to demonstrate what they have learned.

Use reinforcers to increase the likelihood of successful performance. Useful reinforcers are nodding the head, smiling, written praise, verbal praise, and sharing successes with others.

Give regular feedback to the student regarding a patient or other situations. Constructive, non-defensive comments given in an accepting climate of concern allows for enhanced learning.

Allow the student to become aware of how you assess patients, develop goals, prioritize nursing interventions, and evaluate the care you give client and family.

Share unique ways you meet client needs in the home setting, such as adaptations in nursing care.

Share your decision making model and how you access outside resources.

Strive to be confident and professionally secure as a clinical associate.

Student's perception of the clinical associate as a personal coach who want to help them win is powerfully motivating.

Encourage the student to think critically in the clinical setting and to use the problem solving process.

Show the student a sense of humor, thus teaching them the importance of keeping a balance in their nursing career.

Assist the student to become socialized into the world of nursing.

Observe the student carefully, document your observations, and share them with the student.

Evaluate student performance using the evaluation form in the packet. Share the evaluation with the student.

References

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Rice, C.P. (1992). "Strategies and Faculty Roles for Teaching RN Students. Nurse Educator, 17, pp. 33-37.

Viverais-Dresler, G. (1992). "RN Students' Satisfaction with Clinical Teaching in a Distance Education Program." The Journal of Continuing Education in Nursing, 23, pp. 224-228.

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OVERVIEW OF HOME CARE PRACTICUM EXPERIENCES

	ASSESSMENT	PLANNING	IMPLEMENTATION	EVALUATION
Instructor:	May participate in direct observation of specific skills prior to clinical	Provides C.A. with practicum schedule, student name Meets with C.A. and nursing student prior to clinical to review overall plan	Provides support to C.A. by assisting in identifying problem and/or solutions Discusses course, philosophy, goals, objectives Reviews evaluation process, expectations regarding staff nurse responsibilities	Through ongoing conferences with student and C.A. keeps updated on progress Based on feedback from C.A. and student, determines need for course revision
Clinical Associate:	Participates in direct observation of clinical performance and provides feedback on daily basis	Meets with student the morning of first day to review objectives Assists student in development of plan to meet practicum objectives in home care	Identifies and provides opportunities for performing specific skills Incorporates specific learning activities to be done each day Acts as a clinical resource Familiarizes student with policies, procedures, resources specific to home care	Provides oral and written feedback to student and assists in evaluation of progress of student Assists student in identifying areas of strengths and weaknesses
Nursing Student:	Identifies own learning needs	Communicates learning needs Reviews home care objectives and makes plans to meet practicum objectives	Works under direct supervision of C.A. Suggests to C.A. learning experience needed to meet needs Completes activities identified in course objectives as available Meets with C.A. and instructors as indicated	Evaluates practicum Provides feedback to C.A. and instructor Meets with instructor to identify areas needing continued growth

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CLINICAL ASSOCIATES EVALUATION OF THE NURSING STUDENT FOR HOME HEALTH CARE EXPERIENCE

Student's Name_____

Directions: Complete this form at the end of the clinical experience using the following ratings: Score 1 = Poor, 2 = Fair, 3 = Average, 4 = Above average, 5 = Excellent, NA = No Answer

	Rating					
	1	2	3	4	5	NA
1. Arranged with Clinical Associate, ahead of time, meeting time and place and arrived on time.						
2. Obtained a status report of the patient and family.						
3. Reviewed current nursing care (prior to visit).						
4. Observed care given by the Clinical Associate.						
5. Asked pertinent questions regarding patient/family care.						
6. Gave safe, direct patient care under the direction of the Clinical Associate using the nursing process and charted (when possible).						
7. Communicated effectively with the patient and family.						
8. Taught patient/family regarding maintaining health, coping with illness, and the use of medications.						
9. Discussed the major nursing diagnoses, interventions, and evaluation of care (after visit).						
10. Accessed community resources for patient/family as needed.						
11. Discussed adaptations to patient care used in the home setting.						
12. Conveyed a positive attitude toward learning home health care nursing.						
13. Conveyed caring and concern to the patient and family.						
14. Presented professional behavior and approach to patient and family.						

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Discuss student's strengths.

Suggestions for improvement.

Clinical Associate _____ Telephone Number _____

Please return to SPJC Nursing Department of your Education Department.

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CLINICAL ASSOCIATES EVALUATION OF THE NURSING STUDENT FOR HOSPICE EXPERIENCE

Student's Name_____

Directions: Complete this form at the end of the clinical experience using the following ratings: Score 1 = Poor, 2 = Fair, 3 = Average, 4 = Above average, 5 = Excellent, NA = No Answer

	Rating					
	1	2	3	4	5	NA
1. Arranged with Clinical Associate, ahead of time, meeting time and place and arrived on time.						
2. Obtained a status report of the patient and family.						
3. Reviewed the interdisciplinary patient/family plan of care (prior to visit).						
4. Observed physical, psychosocial nursing care given.						
5. Discussed the Hospice approach to pain and symptom control.						
6. Communicated openly with Clinical Associate.						
7. Communicated therapeutically with patient/family.						
8. Discussed adaptations used in giving patient care.						
9. Discussed the major nursing diagnoses, therapeutic communication, and treatment outcomes (after visit).						
10. Taught the patient and family caregiver.						
11. Discussed with nurse, strategies used for effective coping with this type of nursing (after visit).						
12. Conveyed a positive attitude toward learning to care for the dying and grieving.						
13. Conveyed sensitivity and caring.						
14. Presented professional behavior and appearance.						

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Discuss the student's strengths.

Suggestions for improvement.

Clinical Associate _____ Phone Number _____

Please return to the Hospice Education Department.